

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON MEMORIAL HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1125 W JEFFERSON ST FRANKLIN, IN 46131</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the investigation of a State hospital complaint.</p> <p>Complaint: IN00105956 Substantiated, no deficiencies related to allegation are cited.</p> <p>Date of Survey: 09-24-12</p> <p>Facility number: 005001</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Johnson Memorial Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 09/28/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

DX1711

If continuation sheet 1 of 1